Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FREDERICK MERIAN, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-0748-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PROPERLY PAY THE DESIGNATED DOCTORS CLAIM EVEN AFTER THE CLAIM WAS SENT BACK TO CARRIER AS REQUEST FOR RECONSIDERATION."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the Provider is not entitled to additional reimbursement. The Carrier, therefore, respectfully requests the Division determine no additional reimbursement is due for this service."

Response Submitted by: Travelers, 1501 S. MoPac Expwy, Ste A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2011	99456-W5-WP	$300.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated July 01, 2011
   - FEES - W1 – WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA..

   Explanation of benefits dated July 15, 2011
   - Z10F – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. AFTER CAREFULLY REVIEWING THE RESUBMITTED INVOICE, ADDITIONAL REIMBURSEMENT IT NOT JUSTIFIED."

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed an amount of $1,250.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and billed 5 body areas/units in box 24G on the CMS-1500. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The narrative documentation was examined by MFDR to determine what body areas were actually supported as rated. According to 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category II method on the lumbar and DRE Category I cervical and thoracic (spinal region) is $150.00. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis/hip are part of one body area in the fee guideline, the spine/pelvis. As the right hip is part of the pelvis, there is no separate reimbursement for an additional body area. Documentation also supports a Range of Motion (ROM) IR method on the left shoulder (upper extremities) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the two non musculoskeletal conditions of head and face contusions is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) with a MAR of $150.00 each for $300.00. The combined MAR for the MMI/IR exam is $1,100.00.
2. The respondent has already reimbursed the amount of $950.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the additional amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the additional amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 07, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.